ENGINEERS JOINT WELFARE FUND

101 Intrepid Lane • Syracuse, New York 13205 • Phone (315) 492-1796 • FAX (315) 469-3599

Dental Insurance Benefits

STATEMENT OF CLAIM TO BE COMPLETED BY MEMBER

Please Print All Answers

NOTE TO MEMBER: A claim for reimbursement for Dental expense must be supported by an itemized bill which must contain the American Dental Association (ADA) Codes for each service rendered. This section must be **COMPLETED** and **SIGNED** by member before any payment can be made.

1. Member's Name ____________________ Social Security Number ____________________

2. Address ____________________ Telephone No. ____________________

City ____________________ State ____________ Zip____________

3. Date of Birth ____________________ Union Local No. ____________________

4. Spouse's Name ____________________ Birthdate ____________________

5. Marital status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Date of Divorce _________

INSURANCE INFORMATION (MUST COMPLETE)

6. Member: other Dental Insurance ____________________

Address ____________________

Contract or Policy Number ____________________ Dependents covered ____________________

7. Spouse or Unmarried Parent other Dental Insurance ____________________

Address ____________________

Contract or Policy Number ____________________ Dependents covered ____________________

8. Stepchild's other Dental Insurance ____________________

Address ____________________

Contract or Policy Number ____________________

IF CLAIM IS FOR A DEPENDENT, FILL IN THIS SECTION

NOTE: If both parents have Dental Insurance through their employer, claims on dependent children **MUST** be submitted first to the Insurance carrier of the parent whose birthday occurs earlier in the year (month & day only).

9. Dependent's Name ____________________ Date of Birth ____________________

10. Dependent's Social Security No. ____________________

11. Relationship: Spouse _____ Son _____ Daughter _____ Stepson _____ Stepdaughter _____

INSURED'S CERTIFICATION AND RELEASE: I hereby certify the statements hereon and attached are complete and accurate and I authorize any person or institution rendering care, or any other organization in possession of insurance or other benefit information concerning me or my dependents, to furnish and disclose all known facts, including clinical reports, charts, and X-rays concerning this claim.

12. Date ____________________ Member's Signature ____________________
(DO NOT PRINT)

ASSIGNMENT OF BENEFITS

13. In case a member should wish us to pay the dentist direct, complete the following:

I hereby authorize payment directly to Dr. ____________________,
the dental expense benefits which I may be eligible for under this Fund.

14. Date ____________________ Member's Signature ____________________

ATTENDING DENTIST'S STATEMENT

Patient's Name ______________________ Date of Birth ______________

Is this a pre-estimate? Yes No

Is treatment the result of an accident? Yes No Date

Auto accident? Yes No Date

Is treatment the result of an occupational injury? Yes No

Identify missing teeth with "x"

FACIAL

LINGUAL

UPPER RIGHT LOWER

PRIMARY LEFT PERMANENT

LINGUAL

FACIAL

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH# OR LETTER	SURFACES	DESCRIPTION OF SERVICE	DATE OF SERVICE	ADA CODE #	FEE
			Total fee:		

COMMENTS: ____

Dentist's Name ______________________ Tax ID # ______________

Address ______________________ Telephone # ______________

City ______________________ State ______ Zip ______

Date ______ Dentist's Signature ______________________